SECTION 6

Determining the Medi-Cal Percentage

Table of Contents

DETERMINING THE MEDI-CAL PERCENTAGE:

Overview

The portion of costs that can be claimed as allowable for some Medi-Cal Administrative Activities (MAA) is based on the Medi-Cal percentage. Costs may be reduced or "discounted" by the Medi-Cal percentage when the activity benefits or involves both Medi-Cal and non-Medi-Cal populations. Methods for determining the applicable Medi-Cal percentage may vary for each MAA. The Medi-Cal percentage is multiplied against other factors to determine the amount of reimbursement. The Medi-Cal percentage must be determined each quarter and the method used to determine the percentage must be consistent with the methods identified in the MAA Claiming Plan.

MAA That May Require Discounting by the Medi-Cal Percentage

Outreach B1: This activity must always be discounted by the actual Medi-Cal client count or any other method approved by DHS and HFCA.

Outreach B2: This activity must always be discounted by the county-wide Medi-Cal average as published by DHS.

Outreach B3: This activity must be discounted by one of the three CalWORKS Client Count options approved by HCFA. The three approved options are Adjusted CalWORKS Count, DHS Tape Match, and Unadjusted CalWORKS Count.

Medi-Cal Non-Emergency, Non-Medical Transportation: If this activity is provided to both Medi-Cal and non Medi-Cal populations it must be discounted by the appropriate Medi-Cal percentage.

Contracting for Medi-Cal Services and Medi-Cal Administrative Activities: If the contracts administered under this activity provide services to both Medi-Cal and non-Medi-Cal populations, then it must be discounted by the appropriate Medi-Cal percentage.

Program Planning and Policy Development: If the Programs for which planning and policy development are performed serve both Medi-Cal and non-Medi-Cal populations; this activity must be discounted by the appropriate Medi-Cal percentage.

Definition of the Medi-Cal Percentage

The Medi-Cal percentage is the fraction of persons who are actual beneficiaries of the Medi-Cal program. The numerator is the number of the Medi-Cal beneficiaries and the denominator is the total number of persons.

A person who would be Medi-Cal eligible but has neither applied nor has been determined to be enrolled in Medi-Cal, or whose status is "pending," is not to be counted in the numerator of the calculation to determine the Medi-Cal percentage. The term "enrolled" means that the individual has gone through a formal eligibility determination process and that the county social services agency has determined him/her to be eligible and currently able to receive Medi-Cal services. "Share of cost" clients are "spend down" clients, and may or may not be Medi-Cal enrolled at any given point in time. Clients for whom the "share of cost" obligation has not been met are not considered Medi-Cal eligible for this purpose and are not to be included in the numerator of the calculation.

Approval of methodologies for Determining Medi-Cal Percentage

State and federal guidelines require that the methodology used to determine the Medi-Cal percentage be "statistically valid". Currently the five approved methodologies are actual client count, countywide average, Adjusted CalWORKS Count, DHS Tape Match, and Unadjusted CalWORKS Count. These five methodologies are described below. Other methods for determining the Medi-Cal percentage are possible. However, the acceptance of other proposed methodologies will ultimately be based on State and federal review and approval.

The procedure for securing approval is to include the proposed methodology in the MAA Claiming Plan. If the proposed methodology is not approved, any claims that used this methodology will be returned to the LEC unpaid so that the Medi-Cal percentage can be re-calculated using an approved methodology.

LEC's should expect disapproval of a methodology if "staff judgement" or "management determinations" are the basis for calculating the Medi-Cal percentage. The Medi-Cal percentage must be current with the quarter being claimed and must be updated with each invoice submitted to the State Department of Health Services (DHS).

Each allowable claiming activity within a claiming unit may be discounted using a different methodology. Once a method is chosen by a program or claiming unit and approved by HCFA, it must be used consistently for that program or claiming unit in order to provide the most accurate representation of the amount of Medi-Cal activity for that program. *A program or claiming unit can not pick or choose among methods.* Decisions on which methodology to use to calculate the Medi-Cal percentage must be based on the nature of the claiming unit and by the kind of data that is collected on the client population. Following state and federal approval of the methodology, the claiming unit must use the approved methodology until a claiming plan amendment is submitted. Should a claiming unit elect to change methodologies, e.g., from actual count to countywide average, a MAA Claiming Plan amendment must be filed no later than the end of the quarter in which the claiming unit wishes to use the new methodology.

Actual Client Count

A Medi-Cal percentage that is based upon the actual "client count" is determined from the total number of Medi-Cal beneficiaries and the total number of all individuals served by the claiming unit. The total number of all individuals served by the claiming unit is defined in the claiming plan as the target population. The Medi-Cal percentage is the fraction of a claiming units' target population who are actual beneficiaries of the Medi-Cal program. To use this methodology, the claiming unit must define the population "served" and identify the Medi-Cal status of each person. Although a true actual client count would be done on an ongoing basis, a client count that is done for one full month during each quarter for which claims will be made is acceptable. A sampling taken once per year will not suffice to document the Medi-Cal percentage.

To document the Medi-Cal status of clients, staff must record the Medi-Cal number of each person served. This information can be documented on an information collection form or in the client's case record. Another strategy is to compare identifying information that the entity collects on the population with data on the Medi-Cal population kept by the local social services agency. This comparison must be done through electronic tape matches to ensure statistical validity and accuracy.

It should also be noted that county social services agencies may not include information on Supplemental Security Income (SSI) recipients who have Medi-Cal cards. Thus, this population, as well as children in foster care, may not be reflected in any tape match that is done by the LEC. It is also important to remember that the tape match is possible only when the LEC needing the data provides the social services agency with a list of its population and includes the agreed upon identifying information. The social services agency's response will be a single number, the percentage of the defined population who matched the Medi-Cal population.

Using Actual Client Count For Determining The Medi-Cal Percentage

A Medi-Cal percentage that is based upon an actual "client count" methodologies is determined from the total number of Medi-Cal beneficiaries and the total number of all individuals served by the claiming unit.

When contracting for Medi-Cal service/Medi-Cal Administrative Activities and for Program Planning and Policy Development, for these two activities more than one contract or program may be involved. The Medi-Cal percentage may vary by the contract being administered or the program for which planning and policy development is being performed. See Section 8, MAA Summary and Detailed Invoice, for information on determining the Medi-Cal percentage for Program Planning and Policy Development. A similar procedure may be used for determining the Medi-Cal percentage for Contracting for Medi-Cal services/Medi-Cal Administrative Activities.

Countywide Average Percentage

Claiming units may find that the collection of information about a population's Medi-Cal status may be intrusive or inefficient. In these cases, the claiming unit may use the percentage of the LEC's total population which have Medi-Cal cards for its own Medi-Cal percentage. These percentages may vary from year to year and are published yearly in a DHS PPL.

CalWORKS Count

Claiming units which are unified school districts may use the following three additional options which have been approved by HCFA.

Unadjusted CalWORKS Count: Unified school districts may utilize the annual CalWORKS data for the schools in the district to calculate a district-wide percentage of CalWORKS eligibles in the schools in that district. This district-wide CalWORKS percentage may serve as the Medi-Cal percentage.

DHS Tape Match: Local educational agencies (LEAs) which participate in the LEA Medi-Cal billing option have had access to tape matches of school enrollments with Medi-Cal computer eligibility files. These tape matches identify the numbers of students enrolled in a school who are Medi-Cal eligible. Subject to HCFA review and approval, these tape matches may be used as the basis to calculate a unified school district-wide Medi-Cal percentage.

Adjusted CalWORKS Count: For those LEA's which do not participate in the LEA billing option, the district-wide percentage of CalWORKS enrollees may be increased by a factor provided by the State and approved by HCFA, to account for non-CalWORKS Medi-Cal eligible students in the district, such as SSI disabled children, foster children, and those in certain optional eligibility groups.

Note: The free lunch and reduced lunch discount method for calculating the Medi-Cal percentage for school districts is not approved.